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REVIEW ARTICLE

Ambulatory Treatment of the Psychotic Crisis

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■ *Current efforts to improve the community-based care of psychiatric patients often include attempts to encourage the ambulatory treatment of acute psychosis by non-psychiatrists. New therapies and revisions of older methods now allow this to be done with many patients for whom, 15 years ago, state hospitalization would have been the first step in treatment, and often the last.*

Many techniques applicable to the ambulatory treatment of acute psychotic crises can be used effectively by non-psychiatrists. This review describes ambulatory treatment programs for the more commonly encountered acute psychoses. It emphasizes methods which have only recently become available and those which can be used effectively and safely by the nonspecialist. With the skillfully combined use of pharmacotherapy, environmental modification, office psychotherapy, legal aids and community resources, the interested nonpsychiatrist can undertake the ambulatory treatment of many psychotic crises.

ALL AMERICAN PHYSICIANS are witnesses and many are participants in a quiet revolution materially affecting the hundreds of thousands who have had or are destined to have an acute psychotic episode. This revolution, like all major departures in science and in politics, draws its strength from several sources and can be traced to many beginnings. In its background, however, certain events stand out because they summarize and symbolize the longer, slower changes which preceded them. One such event was the address by Dr. Harry Solomon, then president of the American Psychiatric Association, to that Association's annual convention in 1958, in which he made the extraordinarily far-reaching and influential observation that "our mental hospitals today are bankrupt beyond remedy. I therefore believe that our large mental hospitals should be liquidated as rapidly as can be done in an orderly and progressive fashion."[30] This statement came a few years after Delay and coworkers[9] had introduced chlorpromazine in the treatment of psychoses, and shortly after Loomer, Saunders and

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Kline[21] had reported that the monamine oxidase inhibitor iproniazid was of value in the treatment of depressions.

Other milestones in this medical and social revolution were the passage of the Short Doyle Act for Community Mental Health Services in California in 1957[28] and President Kennedy's Special Message to Congress on Mental Illness and Mental Retardation of February 1963.[18] Finally, the publication in 1961 of Caplan's *Principles of Preventive Psychiatry*[6] is a landmark in the development of programs for effective local treatment of psychiatric illness.

Since the mid-1950's, then, psychopharmacological agents have provided physicians with effective alternatives in the treatment of psychotic illnesses where before hospitalization had dominated the bleak therapeutic landscape. Coincident with and probably in part stimulated by the development of effective drug therapies, there have been energetic attempts to revise and modify standard psychotherapeutic techniques to increase their applicability to psychotic disorders and their usefulness to non-psychoanalysts. Linking each of these innovations, and making them available to large numbers of physicians, post-doctoral psychiatric education has reached and maintained a high level of activity: There are now more postgraduate courses in psychiatry and more students in postgraduate psychiatric training courses than in those of any other specialty.[8]

These are some of the more significant roots of the contemporary revolution in the treatment of ambulatory psychotic patients. In the sections to follow, the application of these techniques to acutely psychotic patients will be considered in detail.

What Is Acute Psychotic Crisis?

An acute psychotic crisis is a period of rapid behavioral and subjective change characterized by increasing utilization of private or idiosyncratic symbol systems. It implies the more or less sudden development of a significant disparity between the patient's own criteria for causality, and the criteria held by most members of his own cultural group. His departure from conventional modes of estimating causality produces behavioral changes such as poor judgment, apparent lack of concern for conventional social and moral codes, deterioration of conventionalized personal habits, distractibility, perplexity, elevation or depression in mood or an apparent desynchrony of mood and ideation. A common, probably universal, feature of the acute psychotic crisis is the abandonment of group conventions about logic and symbol manipulation, and the adoption of idiosyncratic logic systems, resulting in disturbance of all aspects of behavior which depend for their effectiveness and acceptability upon sharing most of the symbols and the logic of one's group.

Acute psychotic episodes can be grouped as follows:

I. *Acute mood disorders*—(a) Acute manic psychoses; (b) acute depressive psychoses.

II. *Acute schizophrenic episodes*—(a) Characterized by withdrawal and detachment; (b) characterized by perplexity and disorganization; (c) characterized by hallucinations and/or delusions; (d) characterized by excitement and overactivity.

III. *Acute disorders of perception (acute brain syndromes)*—(a) Following physical trauma; (b) toxic and withdrawal states; (c) associated with metabolic, pulmonary or cardiovascular disturbances; (d) degenerative and abiotrophic.

Acute disorders of perception associated with organic central nervous system damage form a special category of acute psychotic crises. In many instances an etiological diagnosis can be made and specific corrective measures undertaken. However, when treatment based on etiology is not possible, or when acutely disturbed behavior must be managed before treatment based on etiology can have an effect, many of the techniques applicable to the treatment of acute disorders of mood and acute schizophrenic episodes can be utilized advantageously in the emergency management of acute disorders of perception. Because the acute disorders of perception raise so many special questions with regard to diagnosis and specific therapy, they will not be considered further in this review.

Ambulatory Treatment of Acute Mood Disorders

Acute Manic Psychoses—When he contemplates ambulatory treatment of the patient with sudden and severe depression or elevation of mood, the physician's attention and judgment must be focused from the start on the possibility that the patient's seriously defective judgment and

his disturbed mood may lead to self-destructive, socially disruptive or personally embarrassing actions. That is, the physician must decide if the potential for suicide in the depressed patient, or for grandiose failures in judgment in the manic patient, can be prevented with sufficient speed and certainty to justify the risks of ambulatory treatment.

In almost every instance of manic behavior the accelerated and disorganized social and business activities which usually characterize such states can be controlled by means of moderate to large doses of phenothiazine agents such as chlorpromazine (Thorazine®), 200 to 2,000 mg per day in divided doses, or perphenazine (Trilafon®), 48 to 128 mg per day in divided doses. Adequate behavioral control can usually be reached within two weeks by progressively increasing the phenothiazine dosage until a satisfactory reduction in grandiose thinking and manic behavior is achieved. At higher dose ranges, antiparkinson agents should be given concurrently to prevent extrapyramidal symptoms.

Success or failure with such treatment for the ambulatory patient really hinges less on the medications, which are almost *always* effective when properly used, than it does on the availability, in the patient's personal environment, of the supports and protections necessary for ambulatory therapy. Much, therefore, depends on the ability of the physician to estimate and mobilize such support and protection. Are there friends or family members whose positive feelings about the patient have not yet been obliterated by exposure to his grandiosity? Can they be encouraged and trained by the physician to be his collaborators; to encourage the patient to take his medication as prescribed, to discourage his over-involvement in unwise ventures and schemes, to restore and maintain reasonable sleeping and eating patterns and normal living routines? They can be taught that the manic episode will in most instances be relatively brief, and that it will be followed by a return to normal behavior. They can be helped to appreciate the early evidence of a worsening state, and the importance of communicating such observations to the physician. Above all, the physician can help the collaborating friend or relative to understand that the buffeting the manic patient gives those around him will soon cease, and in fact, is likely to cease sooner if it can be tolerated without vengefulness, abandonment or retaliation.

A treatment program otherwise adequate for the ambulatory management of an acute manic crisis can founder because manic patients are extremely wearing to those around them. Broadening the base of responsibility and contact to relieve the pressure on relatives or friends can sometimes be accomplished through the skillful use of helping agencies such as visiting nurse services and day treatment centers, or employing temporary paid companions. The problem of ensuring correct drug intake can be partially assumed in many communities by the visiting nurse service. An informed family attorney can share the important task of maintaining watchfulness and control over the manic patient's tendency to engage in grandiose and unwise business dealings. During the ambulatory treatment of a manic episode in a wife and mother, assistance from the homemaker services available in many areas gives support to the patient and minimizes domestic disruption and the impact of the illness on husband and children.

Acute Depressive Psychoses—Sudden depressions, severe enough to be considered psychotic, usually occur in middle and late adult life in people of two personality types: (1) the labile, moody, dramatic person who may have a series of severe depressions, either alone or interspersed among periods of manic behavior; (2) the person who tends to be highly organized, conscientious, duty-bound and careful.

Psychotic depressions in the second kind of patient usually occur in the fifth or sixth decade, and tend to be characterized by bodily preoccupation, severe agitation and delusions of worthlessness. Paranoid thought disorders with delusions of persecution and ideas of reference quite like those described by patients with paranoid schizophrenia can occur in any psychotic depressive episode. Initially or for their entirety psychotic depressive crises can be manifested chiefly by somatic preoccupations or delusions about the body. Furthermore, such somatic concerns can occur in the absence of patently depressed mood. Therefore, the non-psychiatrist must be especially alert to such cases, since the patients often make their initial medical contact with the internist, general practitioner, or surgeon and not with the psychiatrist.

The suicide risk must be estimated by any physician contemplating the ambulatory treatment of any patient thought to be significantly depressed. No amount of experience with depressed patients can justify an unequivocal statement that a par-

ticular depressed patient is not a danger to himself; we are limited to making statements of *probability* about the danger of a suicide attempt, using a relativistic frame of reference in which the risk of self-destructive behavior is weighed, as carefully as possible, against the over-protectiveness, disruption of life patterns and social and economic expense of treatment in hospital. Fortunately, the majority of patients about to make a suicide attempt have contact with a physician before doing so.[23,24] Physicians thus have opportunity in most instances to weigh the danger of a self-destructive act. What has prevented greater improvement in our suicide prevention efforts lies more in the realm of not asking than in not having the opportunity to ask.

A history of previous suicide attempts, however "gestural" they may seem; acknowledgment of current thinking about suicide, especially if particular devices and methods are being considered; expressions of pervasive and unyielding hopelessness about the future; a history of suicide or suspicious sudden deaths in family members; evidence that the patient has begun to "get his affairs in order"; and observable improvement in mood independent of effective treatment or improvement in the patient's life situation—all these are useful measures of the suicide risk. The presence of several of these features indicates a degree of suicide risk incompatible with ambulatory treatment, and should thus lead the physician to encourage the patient toward voluntary entry into a psychiatric hospital. Should such indicators of risk be noted, and should the patient decline to enter a hospital voluntarily, the physician is obligated to communicate his estimate of risk to a responsible family member and encourage that person to petition the appropriate court in his jurisdiction to arrange psychiatric examination for the patient, and, if indicated, commitment to hospital.

In communities where psychiatric consultation is available, either privately or at public clinics offering such services, the non-psychiatrist may wish to request a psychiatrist's opinion about the suicide risk. While individual psychiatrists and psychiatric clinics are often unable to offer *treatment time* soon enough to meet the needs of the acutely depressed patient, they are often able to provide the kind of brief *evaluative* service which can help the non-psychiatrist to decide whether to undertake treatment of such a patient himself.

If the estimate of risk in a depressive crisis is such that ambulatory treatment seems justified, the non-psychiatrist now has at his disposal a relatively new group of effective agents. Antidepressant drugs, properly used, can ameliorate depressive symptoms to a clinically useful degree in about 75 per cent of cases.[2,7] Curiously, they seem less effective in milder, non-psychotic depressions. Two classes of antidepressant drugs are available. One group, the monamine oxidase inhibitors, is represented by nialamide (Niamid®), phenyelzine (Nardil®), isocarboxazid (Marplan®), and others. These agents, while useful, sometimes produce troublesome and, rarely, dangerous side effects.[15] Safe and effective use of them requires more experience of the physician and greater frequency of contact with the patient than is the case with the other class of antidepressants, the iminodibenzyl derivatives such as imipramine (Tolfranil®), amitriptyline (Elavil®), desipramine (Pertofrane®), and nortriptyline (Aventyl®).

It is wisest for the non-psychiatrist interested in developing skill in the drug therapy of severe depressions to familiarize himself thoroughly with one or two members of the iminodibenzyl group. Generally speaking, it takes one to three weeks to ascertain the ultimate effectiveness of these drugs. In a physically well, intellectually intact patient of normal size a starting dose of 25 to 50 mg per day of one of these compounds would be appropriate. Over a one-to-three-week period a stepwise increase to a maximum of 50 mg three or four times a day is warranted unless significant improvement occurs earlier, at which point the dose should be maintained unchanged for four to six weeks. Should the remission continue, a gradual reduction to a maintenance dose of 50 to 100 mg per day should then be attempted and this dose continued for three to six months before cautious attempt at further reduction.

Concurrent use of the iminodibenzyl and monamine oxidase inhibitor drugs has produced several severe and a few fatal toxic reactions.[2,4,29] Before prescribing an antidepressant drug, therefore, the physician must be certain that the patient has not been taking any drug of the other class. Should the patient already be using any antidepressant drug the physician must continue to use antidepressants of the same class or he must ensure an interval of at least one week free of all antidepressant medication before instituting treatment with a representative of the other group.

Psychiatrists and non-psychiatrists alike must

bear in mind that many patients who do not respond to antidepressant drugs or who respond to them inadequately or too slowly can look forward to rapid, perhaps lifesaving improvement with electroconvulsive treatment. In some communities, clinics or psychiatrists in private practice have established programs for administering electroconvulsive therapy to outpatients; the availability of such a service may make it possible for the nonspecialist to have an active and important role in the treatment of severe acute depressions, collaborating with the psychiatrist or psychiatric clinic during a course of ambulatory electroshock therapy.

The severely depressed patient is rarely a proper subject for analytically oriented psychotherapy. However, with remission from an acute depressive crisis, psychotherapy may be indicated for those patients whose depressive episodes appear to have been exacerbations of preexisting neurosis, or the result of maladaptive or inadequate efforts to cope with contemporary stresses. Such patients should be referred for formal psychotherapy, if referral is possible, when their acute symptoms have subsided.

But "psychotherapy" in the sense of the physician's thoughtful effort to utilize information about the patient's personality, illness, and situation to maximize his therapeutic impact *during* the acute depressive crisis, must always be part of the treatment program of depressive episodes. Depressed people have an unsupportable burden of guilt, are convinced of their worthlessness and the hopelessness of their situation, and are unable to make decisions without great pain. The physician should avoid adding to these problems. Although he may himself be uncertain about outcome and procedure, the physician should avoid placing any responsibility for treatment decisions on the patient. Relating to the depressed patient in a sentimental, emotional or effusive way will in almost every case impair the physician-patient relationship. Exhortations, appeals to "willpower," moralizing, pontificating, and encouraging the patient to "snap out of it" will only add to his already overwhelming sense of guilt and worthlessness. Preferable but often difficult to achieve is a professionally competent, mildly formal, unsentimentalized attitude. One must beware especially of the tendency of older depressed patients to provoke in us feelings of pity and protectiveness, or their equivalent opposites, annoyance and rejection.

Occasionally, the family physician with long previous contact with the patient will know from the start or will soon learn that the acute depressive crisis is related to a specific psychological injury. This may be a personal, material or physical loss, or the loss of a *symbol* of personal, physical, or material strength. Retirement, bereavement, injury and illness are often associated with the development of acute depressions. In such instances, in addition to using the pharmacological and psychotherapeutic measures already outlined, the physician should encourage the patient to discuss his feelings about the loss. He should then consider, with the patient, what can be done to find substitutes and replacements for what has been lost. "Crisis-oriented psychotherapy"[20] is the more effective the sooner it is undertaken after the loss occurs; therefore it is often done more effectively by the non-specialist whose previous contact with the patient gives him earlier and more accurate clues about changes in the patient's life that are associated with the onset of depression.

Depressed patients make decisions poorly, and often with great pain. The patient's need to make decisions and his difficulty in responding effectively to that need can deepen his conviction about his own impotence and uselessness. For the acutely depressed the physician should simplify and reduce the need for making decisions by transferring decision-making temporarily to others, and by arranging to postpone decisions that cannot be transferred.

The informed collaboration of responsible relatives and friends can be invaluable assets in treatment if these people can be encouraged and taught to serve as companions to patients with a known but not prohibitive self-destructive potential. They can be "deputized" by the physician to stimulate the patient to maintain the normal routine of daily life. It is especially valuable for the physician to assure the patient and his family that bed rest is *not* necessary for the physically well but depressed, and can in fact be highly detrimental. The preservation of the patient's normal pattern—daytime: activity; nighttime: sleep—with conventional meals at regular mealtimes, minimizes the regression and social disruption which can develop in a depression.

Such measures can thus help to prevent both the physical deterioration and the destruction of habits and coping skills which will become increasingly important to the patient as he recovers.[26]

Ambulatory Treatment of Acute Schizophrenic Episodes

Few would now contend that "schizophrenia" is a single disease entity, and most students of schizophrenia now agree that it has a complex, multicausal basis and a widely varied array of manifestations. However, the view that the several schizophrenic reactions have a common core of disturbances "in reality relationships and concept formations, with affective, behavioral, and intellectual disturbances in varying degrees and mixtures"[10] is widely held in this country. Most American psychiatrists would also agree that the schizophrenic reactions "are marked by strong tendency to retreat from reality, by emotional disharmony, unpredictable disturbances in stream of thought, regressive behavior, and . . . by a tendency to 'deterioration.' "[10] The standard subcategories of schizophrenic reactions (simple, hebephrenic, catatonic, paranoid and others) have little value in deciding upon treatment, and little relevance to outcome. They do not lead to useful choices among the kinds of treatment available.

A view of the schizophrenic reactions in which the subtypes are arranged along the continuum, "verbal and/or motoric activity," gives the physician with minimal academic interest in the problem of schizophrenia a useful guide to management and treatment:

SCHEMA OF SCHIZOPHRENIC REACTIONS ACCORDING TO LEVEL OF ACTIVITY

withdrawn and depressed	perplexed and disorganized	delusional and hallucinative	excited and overactive

Low ——————————————— High

Verbal and/or Motoric Activity Continuum

The nature of the symptoms and the social impact of an acute schizophrenic crisis will vary substantially, depending on whether the predominant symptoms of the episode are characteristic of the "low activity" or "high activity" extremes of the scale. In general, patients with symptoms characteristic of underactivity come to the attention of the physician later in the course of the episode because their disorder impinges less dramatically on the large and small social groups in which they live. Awareness of their symptoms as reflected in appropriate helping responses from the environment may, for such patients, be long delayed. Especially in those whose social contacts before the crisis were sparse and transient, the acute underactive schizophrenic episode may progress toward a chronic state with no formal medical or public intervention. On the other hand, in the case of the acutely overactive, delusional, excited patient, even if his illness occurs in a social network characterized by impoverishment and impermanence of relationships, seldom does the condition go unrecognized; and almost always therapeutic effort of some kind is brought to bear. The term "acute psychotic crisis" almost always conjures up the image of an excited, delusional, perhaps threatening patient. To improve our detection of these episodes, it is important to keep in mind the frequency of psychotic crises that are characterized, instead, by withdrawal and inaction. Such patients have a strong proclivity for a quiet, socially "untroublesome" deteriorating course if untreated.

The Overactive Schizophrenic Crisis

Beyond the matters of recognition and case-finding, the activity continuum has obvious implications for appropriate environmental-supportive responses, whose design and implementation can be one of the physician's most important contributions to the treatment of the patient with an acute schizophrenic crisis. The overactive, delusional and excited patient almost always has severely impaired judgment. Unless he is temporarily helped by others, his defective judgment may lead him to make decisions and engage in behavior consistent with his private perceptions but not with reality. Such behavior can disrupt his social relationships, impair his economic status and plant the seeds of later feelings of humiliation and self-doubt, all of which may outlast by far the acute psychotic episode itself. In many respects the schizophrenic patient who is overactive and overproductive resembles the acute manic patient and poses similar social and therapeutic problems. Similar efforts by the physician to encourage the collaboration of the healthier members of the patient's immediate social group are indicated. Such collaborators are not always available; they may already be too alienated or for other reasons disinclined to accept such roles. Or the patient's pathological activity and impairment of judgment may be such that the virtues of ambulatory care are overshadowed by its difficulties or dangers.

In such situations the physician can turn for help with treatment to public facilities and agencies. While these vary from community to community, they tend to include such services as psy-

chiatric clinic evaluations, voluntary day hospital or general hospital psychiatric units, and recourse through the courts for involuntary examination and treatment. Even in the case of the acutely excited or overactive schizophrenic, the patient's willingness to cooperate with the physician and accept his recommendations, and the availability of friends or relatives interested in the patient and willing to tolerate his pathological behavior for a while, can justify and recommend an effort at ambulatory therapy. In the absence of these conditions or in the face of the patient's unwillingness to use them, the physician should recommend to the patient, his family or friends that the patient voluntarily enter a hospital. Failing that, involuntary examination and treatment should be requested.

Should ambulatory therapy of the overactive schizophrenic patient seem feasible in terms of the criteria noted above, the physician will again find the phenothiazine drugs of special value. A parallel may be drawn between the activity continuum of schizophrenic symptoms and the stimulant-sedative continuum of the phenothiazine drugs, which may be charted as follows:

STIMULANT-SEDATIVE CONTINUUM OF PHENOTHIAZINE DERIVATIVES

Stimulant	*Mid-range*	*Sedative*
	triflupromazine	promazine (Sparine®)
fluphenazine	perphenazine	chlorpromazine
trifluoperazine	prochlorperazine	thioridazine

For example, the more potent, low-dose phenothiazine derivatives such as fluphenazine (Prolixin®, Permitil®) and trifluoperazine (Stelazine®) tend to have little sedative effect, and instead, may be mildly stimulating. They would, therefore, ordinarily be less effective for the rapid control of a hyperactive schizophrenic patient than phenothiazine compounds with some sedative action but without stimulating effects. Among the more sedative phenothiazines, chlorpromazine and thioridazine (Mellaril®) are outstanding examples. There is, in addition, a mid-ground of phenothiazine derivatives without either distinctly sedative or stimulating effects. Trifluprom azine (Vesprin®), perphenazine and prochlorperazine (Compazine®) are examples of this middle group.

It is well for the physician to familiarize himself in detail with one representative of each of the three classes of phenothiazine compounds: the stimulating, the sedative, and the "middle" group. Taking chlorpromazine as an example of a sedative phenothiazine, its appropriate dose range in the management of an acutely overactive, physically healthy young adult schizophrenic patient would be between 200 and 2,000 mg per day in divided doses. At the higher end of this range, concurrent administration of an antiparkinson compound is advisable because of the frequency with which uncomfortable but reversible extrapyramidal symptoms would otherwise develop.

There are problems associated with the high-dose administration of phenothiazine compounds. These include atropinic effects, hypotension, amenorrhea, weight gain, and, with prolonged use, pigmentary deposits in exposed skin, cornea and lens. These problems have received extensive but appropriate attention.[5,16,22] An entirely different problem associated with the use of phenothiazines in acutely psychotic patients has, however, received inadequate attention despite the fact that it has produced far more misery and far greater waste of human energy, time and material resources than all the forms of pharmacological toxicity with the phenothiazines. This is the widespread and strangely enduring tendency of inexperienced physicians to treat severely psychotic patients with inadequate doses of these drugs, and to withdraw or reduce the medication as soon as the patient shows a satisfactory response. Forrest[13] gave a dramatic picture of the consequences of this unfortunate tendency, which would certainly subside if more physicians understood that clinical improvement no more justifies cessation of phenothiazine therapy of a patient with acute schizophrenia than the achievement of a euthyroid state is an indication to discontinue thyroid supplement in the myxedematous patient.

In the younger acute schizophrenic patient with no history of previous psychotic crisis, maintenance phenothiazine therapy should be continued for six months to one year. In the older patient with a history of previous psychotic crises, especially if the earlier episodes have lasted for several months, it is advisable to continue phenothiazine maintenance dosage *indefinitely*.[1,3,12,14]

So much has been written regarding the techniques, indications and efficacy of psychotherapy with schizophrenic patients that even a summary of the subject would require volumes. For the purpose of this review, and with awareness of the extreme simplification involved, I would say that effective psychotherapeutic management of the acutely overactive schizophrenic patient depends

particularly on the physician's ability to preserve a clear image of himself as a physician treating an illness, and therefore willing to take an active and directive role in the patient's affairs as far as he must to protect the patient and hasten his recovery. At the same time he must recognize that this role is temporary and he must abandon it by stages in exact synchrony with the progressive return of the patient's ability to function without such direction.

Beyond that, after remission from an acute overactive schizophrenic crisis some patients express curiosity, and a willingness to learn about the interplay of the experiential, developmental and constitutional factors in the development of their illness with an eye toward reducing their vulnerability to subsequent crises. For these patients, referral for expert psychotherapy is in order wherever possible after the disorganization of the acute crisis is over. During the crisis itself, neither the patient's nor the physician's need to "understand" can be constructively satisfied.

The Underactive Schizophrenic Crisis

The withdrawn, underactive schizophrenic patient, when he comes to the attention of the physician, presents a treatment challenge quite different from that of the overactive patient. Apathy, anergy and indifference are the hazards, often along with profound depression and a crippling loss of responsiveness. Here, the physician's conviction that the withdrawal and alienation of the patient are symptoms, rather than choices, will usually lead him to take a position with the patient which communicates his expectation that improvement can be achieved and the patient restored to contact with his human environment. Fundamental to a helpful relationship with the withdrawn and apathetic schizophrenic patient is the physician's awareness that his patient fears and distrusts personal closeness. Thus, the physician must avoid being intimate, informal or too personal with the patient. Instead, the unsentimental, professional, somewhat formal approach described previously as particularly helpful to the severely depressed patient can be recommended, as well, for the physician undertaking the ambulatory treatment of a schizophrenic crisis characterized by apathy and withdrawal. Formal psychotherapy for such patients should not be attempted or evaluated until an adequate remission has been achieved, as with the overactive schizophrenic patient previously described.

Drug therapy for the withdrawn and underactive schizophrenic patient differs from that for the overactive, in that a rational choice of a phenothiazine agent would lead the physician to select a less sedative, more stimulating compound such as fluphenazine or trifluoperazine. Avoidance of parkinsonian side effects through the concomitant use of an antiparkinson agent is especially important with these phenothiazines. The inadequately informed physician tends to undertreat these patients, and to treat them too briefly. A typical dose of fluphenazine for such a patient would be 10 to 60 mg a day; of trifluoperazine, 20 to 100 mg a day. Again, adequate maintenance therapy should be continued, depending on the past psychiatric history, for six months to a lifetime after an adequate remission is achieved. The physician must bear in mind when treating withdrawn and apathetic schizophrenic patients with one of the low dose, high potency phenothiazines, that continued inactivity, disinterest and withdrawal are more likely evidence of inadequate than of excessive treatment.

Depression frequently coexists with the indifference, apathy and social impoverishment of these patients. Special consideration must be given by the physician to the risk of self-destructive behavior in any effort to treat them outside the hospital. Criteria similar to those previously outlined for the estimation of risk of suicide in psychotically depressed patients are applicable to inactive schizophrenic patients.

The role of supportive relatives and friends with the withdrawn schizophrenic differs from their role in the ambulatory treatment of overactive schizophrenics. With the apathetic patient, friends and relatives are of greatest value to the treatment program if they can be encouraged to serve as "extensions" of the physician by supervising the proper use of medication and helping the patient maintain reasonable patterns of hygiene, nutrition, sleep, physical activity, work and recreation.

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